Abstract

This article contends that there is a growing, if uneven, crisis in public sector trade unionism masked by relatively high membership figures that obscure a weakening of trade unions in the workplace that leaves hollowed out organization vulnerable to further legislative and employer-led onslaughts. The weakening is not inevitable but to overcome it requires a refocusing of organizing efforts on the everyday concerns of members such as understaffing and the provision of better public services. Only with an engaged membership will national issues and wider campaigns have any material force. Having outlined a general argument, the article takes as illustrative the nature and performance of trade unions, and particularly UNISON, during the Mid Staffordshire Hospital crisis.

Keywords

Crisis; Mid Staffordshire; public sector trade unions; workplace organization

The Crisis of Public Sector Trade Unionism: Evidence from the Mid Staffordshire Hospital Crisis

Almost 20 years ago, the TUC responded to falling trade union membership by introducing the 'organizing model' through its New Unionism strategy (Heery 1998). The atrophy of the British trade union movement has continued regardless, with fewer absolute numbers and an even greater reduction in density, from 32 percent in 1995 to 26 percent by 2011 (Brownlie 2012). Trade union density in the public sector is higher, standing at 56.5 per cent in 2011, compared to 14.1 in the private sector. As a result, over 62 percent of union members are in the public sector (ibid.). The immediate fortunes of the movement appear therefore to rest on the resilience of this sector. As Richard Hurd has argued in the US, however, it would be a mistake 'to conclude that public sector unions are strong, stable, and immune to the external and internal influences that have brought private sector unions to their knees' (cited in Burns 2015: 53-4). Relatively high density should not be allowed to hide falling membership: from 4.11 million in 2009 to 3.88 million in 2011, with a loss of 186,000 members in 2010-11. Nor should density figures mask the significant decline in collective bargaining. According to the authors of the latest WERS (2011):

> Collective bargaining takes place in less than three fifths (57%) of public sector workplaces, setting pay for a little over two fifths (44%) of public sector employees, down from over two thirds in 2004. Strongly unionised workplaces where 100% of employees have their pay set by collective bargaining have been a rarity in the private sector for some time. But they are increasingly uncommon in the public sector too (van Wanrooy et al. 2013: 22).

According to the Institute of Fiscal Studies (2014: 1) 'The public sector workforce stood at 5.7 million in mid-2013, and made up just under 20% of total employment, low than at any point in at least the last 40 years'. On-going cuts in public expenditure pose an acute threat to public sector unions and hence the wider fortunes of British trade unionism. As well as expenditure cuts directly shedding jobs, there has been a general erosion of the wages of public sector labour especially in the years since the economic crisis of 2008 and the onset of austerity, adding demoralisation to rising insecurity. The New Economics Foundation (NEF) found that the public sector had been hard-hit by 'the sequence of a 2-year pay freeze (three years in local government) and then a 3-year pay cap', the effect of which was 'to reduce median and average gross pay in the public sector by a prospective 13% across the period' (NEF 2013: 8). As a consequence it estimated that: 'one million public service workers are on low pay, including health and social care workers, school staff and local authority employees' (ibid.: 6). According to UNISON'S own research: 'When the national minimum wage was introduced in 1999, the bottom NJC [National Joint Council] pay point was over 24% above it. Now it's just 2% above' (http://www.unison.org.uk/njc-14-44). Alongside the erosion of wages, workers have likewise experienced pension changes that have seen higher employee contributions, lower benefits, longer working lives and a reduction in the rate of inflation proofing. Moreover, the widespread anger towards these changes has been dissipated by ineffectual union action. Hurd's warning is even more apposite given the 2015 election of a Conservative government openly hostile to public sector unions and with the prospects of even greater expenditure cuts.

Trade unions have performed poorly even in the arena that they feel most confident – the demands that can be quantified. Unions frequently channel a variety of grievances

into wage demands – one has only to remember the not so historic claims for payment of 'dirty money' and compensation for injuries as alternative to demands for clean and safe working environments. A substantial rise is easier to negotiate than respect at work. Yet it is conditions and relations at work that frequently come to the foreground when talking to public sector workers. Teachers' main employment concerns are workload and the growth of targets and intrusive monitoring. Healthcare workers worry about understaffing, arbitrary rotas, sickness monitoring and the extent of bullying. Civil servants complain about the management of change, understaffing, targets and performance monitoring. Without necessarily explicitly connecting the effect of these practices, workers in all sectors are concerned the impact of them on their ability to perform a public service. As Burns (2014: 69) notes 'Caring intensely about their work, public workers often gravitate[d] towards issues that motivated their membership, and dovetailed with the public good'. Nevertheless, focused and systematic trade union opposition to manifestations of management's control of the workplace and the related degradation of services is muted in the UK and workers' complaints largely unorganised.

There are a number of reasons for the lack of unions' workplace effectiveness. Relatively high density and coverage obscure evidence that unions in many public sector workplaces have been effectively 'hollowed out'. The fortunes of UNISON, the largest public sector union with 1,254,000 members, are crucial for unionism as a whole. Since its formation in 1993 it has lost 250,000 members despite a number of strategies to raise the figure back to 1.5 million (Waddington and Kerr (2105). One of the objectives was to use branch development and organising plans to require branches to implement policies directed towards increasing the number of lay representatives (UNISON, 1998) and to bring about a ratio of 1 lay representative for every 50 members. However, the proportion of members with a lay representative present at their workplace fell from 72.3 per cent in 1999 to 70.2 per cent in 2000 and then to 52.3 per cent in 2009 (ibid. 2015: 9).

UNISON is a particular example of hollowing out, but an important one. The process across public sector unions is uneven (Simms et al. 2013) as the contexts in which unions operate (concentrations of employment, occupational identities and disruptive capacities) and their leaderships and strategies differ markedly: the firefighters' union

is not UNISON. Nevertheless, there are some general features at work. The merger of unions has been a largely bureaucratic and defensive process. One of the things sometimes lost in such mergers is a sense of occupational identity as a source of organisation. To be an engineer or a patternmaker was a source of pride and self-esteem that formed the basis of demands for respect and craft control of work processes. UNISON, despite coming into the world with a large nursing membership, has failed to build upon this base and struggles to recruit nursing students. The Royal College of Nursing (RCN) brings apparent prestige and is focused solely on nurses. Where nurses are present in UNISON they are more likely to be represented by non-nurses 'with the consequence that many health professionals may view UNISON as a union for grades other than their own' (Waddington and Kerr 2015).

While it can be argued that craft consciousness led too frequently to sectionalism (Hobsbawn 1978), its atrophy and its lack of representation within trade union structures has resulted in a marked lessening of disputes over changing labour processes. Trade union officials in UNISON, the biggest public sector union in the UK, cover wide areas and very general categories of workers. In local government representation includes numerous job titles such as teaching assistant, social worker and environmental health officer. In the health sector, the job categories include nurses, health care assistants, administrative workers, porters, and professions allied to medicine. Moreover, officials are moved around from one sector to another as gaps arise. The result is that officials tend to be generalists as expressed by one local government official complaining about social worker members: 'they think they are different from librarians' (fieldnote). It may well be that a redundancy is a redundancy wherever it happens (although it would be important to examine the contexts – redundancies can be instances of trade union victimizations or racial discrimination). To imply, however, that you might need to know nothing of social workers' professional codes of practice, in order to give guidance or promote organization is mistaken. Acting as a generalist can desensitize officials from the need to listen and to use opportunities to generate effective responses and to organize around issues such as the inappropriate use of unqualified staff or heavy caseloads that result in mistakes for which social workers are dismissed ('Official sacked over Baby P case'. *BBC News*. 2008-12-01)

Even where professional matters are not directly the issue, lack of focus on other workplace issues can cause serious problems for members and a consequent alienation from their organizations when higher levels of the union do not take the issues sufficiently seriously enough. Fisher (2005: 159) maintained that the union Public and Commercial Services (PCS) demonstrated: 'an as a yet too uncritical understanding of the significance and future potential for the degradation and devaluation of work' and that this failure signaled a crisis in public sector trade unionism. Similarly in a later response to the introduction of Lean techniques to HM Revenue and Customs, PCS actively promoted national union action for increased wages, against changes in pensions and redundancy compensation, but effectively undermined action against the degradation of work through Lean reorganization of the labour process (Author A et al. 2012). Elsewhere, teaching unions accepted many of the elements of workforce remodeling that promised (without delivering) short-term benefits while weakening teacher autonomy and control (Author A and ANO 2012). With few exceptions (see Darlington 2009 on the Rail, Maritime and Transport union), organisation for control of the production process appears to present trade unions as institutions grave difficulties. Public sector unions, with their weak tradition of workplace bargaining, appear to experience the problem more intensely.

The contention that there is a growing crisis is reinforced here through analysis of union responses to workplace change and the deterioration of care at Mid Staffordshire hospital. Evidence to the Francis Inquiry (2010-12) demonstrates that the Royal College of Nursing (RCN) and UNISON had no strategy for integrating issues of professional codes and concerns with the standard of patient care with trade union demands. As a result unions neither engaged effectively with issues of understaffing, work degradation and intensification, nor with the resulting poor healthcare provision. Consequently patients and relatives in the form of *Cure the NHS* (CNHS) came to view health service unions as narrowly self-interested and complicit in excess deaths highlighted by official reports. Rather than being seen as part of the coalition for better healthcare, unions came to be seen in Mid Staffordshire as part of the problem.

The argument is constructed by first examining literature on public sector unionism to establish that there is evidence that experiences at Mid Staffordshire are not unique

and that rather than being exemplars of union renewal public sector unions are being hollowed out. Proceeding from the Methodology, that both justifies the use of the Francis Inquiry as a primary source, and reinforces the claims that the experiences documented are paralleled elsewhere, the article looks at the evidence presented by the RCN and UNISON to illustrate their practice at Mid Staffordshire, before concluding more positively that the integration of both professional codes of practice and the employers' duty of care into trade union demands would impact on day-to-day practice, enhance public services and improve the morale and conditions of employees and increase their engagement with unions.

The Hollowing Out of Public Sector Unionism

The Donovan Commission's (1968) report on employment relations centred on the private sector, particularly the engineering industry, reflecting political concern with unofficial strikes in heavily unionized manufacturing industries (Fox and Flanders 1969). In the intervening period, governmental concern has largely migrated to the public sector. Although the number of strikes are shared almost equally between public and private sectors, in 2010 over 80 percent of all days lost were in the former, a reflection of larger numbers of participants (Office for National Statistics 2012). Higher trade union density and an increased propensity to strike also account for academic interest from those seeing in public sector unions the chance for a revitalized union movement. Darlington (2010: 129), for instance, contends that there is: 'important, albeit often neglected, evidence of continuing resilience and even combativity in certain areas of employment, notably within the public sector'.

Fairbrother (1994, 1996, 2000) has been consistent in maintaining that the decentralization of management decision-making has stimulated a process of union renewal with the latter viewed as democratic, participatory and locally based forms of organization. Fairbrother et al. (2012) reiterated that the changing organization of the state sectors provides a dynamic for structural change in public sector trade unions that in turn presages union renewal. Examining New Public Management (NPM), and the consequent enhancement and devolution of management power, they assert that attempts to marginalize trade unions 'appear to have provided the impetus for union renewal and revitalisation' (2012:5). Their judgement of the extent of renewal is ambiguous and qualified, but, nevertheless, contends that renewal is occurring,

evidenced by a 'long-term trajectory towards more participative forms of representation, accountable leaderships and an activist approach to both managerial initiatives and government policy' (2012: 210). Moreover, the discussion is generalized beyond their specific study to suggest that renewal claims have wider purchase across the entire public sector. Not only is there an assumption of a single 'public sector labour process', the work is also international and comparative, further suggesting its generalisability. In contrast, over a long period, other narratives describing developments in public sector see no evidence of successful union renewal (see, for instance, Colling 1995 on local government unionism; Author A 2004 on teacher unionism). A number of studies focusing on the National Health Service (NHS) unionism also give little cause for trade union optimism.

Conservative governments before 1997 implemented features of NPM in hospitals (fragmentation through establishing Trust hospitals, centralization through target setting, privatization and marketisation) that established the recognized preconditions for union renewal. Lloyd (1997: 429) reviewing NHS workplace unionism contended that the 'evidence of "renewal" in these studies is relatively limited'. The central tenets of NPM continued under subsequent Labour governments, together with additional promotion of social partnership with trade unions and structures established at national, regional and at local levels to ensure that union representatives had adequate time and support to participate in the implementation of the *Agenda for Change* (2004). The less hostile government stance made it no less difficult to promote strong local union organization. Bach's (2004) study of employee participation and union voice, focused on nursing and ancillary staff in three contrasting Trusts, documented common issues of union powerlessness and demoralization. Even where relations with management were good, unions were threatened by the exclusion of union representatives from various groups, a practice that 'did not support the principle of partnership working' (ibid.: 12). Where density was high (60 percent), members 'were relatively passive and their reluctance to take on representative roles encouraged little turnover among a handful of long-serving staff-side members (ibid.: 14). Bach's conclusion was that there is 'a widespread staff perception that [unions] have little control over what happens at their workplace and that their voice is not heard' (ibid.:18).

Evidence suggests that, notwithstanding UNISON's status as an 'organising union' (Waddington and Kerr 2009), union vibrancy at the workplace has been limited and its influence especially over issues of job control. Bryson et al (1995: 132) noted that 'by blurring professional demarcations attacks the power of the professional organization at its heart, i.e. by shifting control from health professional to manager about how a job is done and what skills are required to do it'. Employer strategies have remained constant, with Upchurch et al. (2008: 111) detailing how social partnership has aided the further detachment of unions from opposition to organisational and labour process changes:

> Management hostility or support could constrain union renewal opportunities, the latter by incorporating union representatives in the management of workplace change that employees experienced as increased surveillance and exhortation to achieve performance targets.

Little wonder that their survey found only 21 per cent of surveyed employees and 24 per cent of those who were union members agreed or strongly agreed that 'unions make a difference to what it is like to work here' (2008: 129).

The 'what it is like to work here' and particularly the impact of changes on professional practice are frequently not integrated into industrial relations studies of hospitals. Cooke's (2006a) findings that nurses saw work intensification as the main factor affecting standards of nursing care and, (2006b), that union representatives were overwhelmed by disciplinary procedures and frequently bypassed by managers utilizing informal mechanisms outside the formal disciplinary procedures, have not encouraged considerations of how trade unions address these issues.

Methodology

This article focuses on the union failure to integrate professional issues of patient care and trade union practices and the consequences for membership engagement. The article uses evidence from trades unions given to *The Mid Staffordshire NHS Foundation Trust Public Inquiry* (2013) (hereafter Francis Report) as its primary source. The inquiry chaired by (now Sir) Robert Francis QC was established to investigate what the various NHS local, regional and national commissioning,

supervisory and regulatory bodies and systems had done (or not done) to detect or prevent poor care at Stafford which had resulted in some 400-1200 patient deaths. The inquiry was both in-depth and long-running, taking oral evidence from 164 witnesses as well as 87 witness statements and totaling a million pages of evidence.

Stafford hospital was a district general hospital in the West Midlands of England. It was the largest part of the Mid Staffordshire Hospitals NHS Trust, later to become a Foundation Trust in 2008. Five official reports into the deaths of patients culminated in the Francis Report (2013). Care was poor before 2006, but was seriously worsened by redundancies and restructuring that took place in early 2006 cutting staffing levels, changing skill mix and subordinating patient care to financial targets necessary for achieving "Foundation Trust" status.

In mid 2007 the Healthcare Commission (HCC), the then NHS care regulator, was warned that Stafford seemed to have unusually high death rates for its patient mix. Eventually immense pressure from the local CNHS campaign group, formed by relatives of those who had died, forced a Public Inquiry. Francis found misdiagnosis and fundamentally poor care in several parts of the hospital. Amongst other things: patients were often left on commodes or in the toilet for far too long; often left for long periods in sheets soiled with urine and faeces; meals were placed out of reach and taken away without being touched; cloths were used both to clean ward surfaces and toilets; and receptionists without medical training assessed patients coming in to the Accident and Emergency department (A&E) (see Francis Report 2010: Executive Summary).

Francis found morale was low and reported: 'I heard much evidence suggesting that members of staff lived in an atmosphere of fear of adverse repercussions in relation to a variety of events. Part of this fear was promoted by the managerial styles of some senior managers' (Francis Report 2010: B. 37). His conclusions were especially critical of Trust leadership and the impact of the Trust Board's decision to try to save £10m in 2006-07, as part of its desire to gain Foundation Trust status.

There are a number of justifications for using the Francis Report as the prime source for the research. Firstly, it enables the research to build on works already highlighted

in the literature review. The profile of trade union membership at Mid Staffordshire was unlikely to vary much from that in hundreds of other hospitals. Certainly none of the national officers giving evidence claimed any exceptionalism as an explanation for the practice of the unions and their own ignorance about what was occurring: just the reverse – the reason why union officials were not sensitive to the problems was there were so many institutions in which circumstances were similar to Mid Staffordshire that it did not warrant special consideration. A number of the witnesses indicated that trade union practices and patient experiences of care were little different elsewhere. A subsequent review by Sir Bruce Keogh (2013), the Medical Director for England, confirmed that the themes identified by Robert Francis were indeed common to a greater or lesser extent in the 14 Trusts he examined and it has become clear since that there are systemic problems across the NHS in which performance management, targets, bullying and insufficient staffing establishment form a toxic mix.

Thirdly, while replicating findings in a large number of hospitals, the Inquiry uniquely examined written evidence and verbal testimonies under oath from a range of sources including union representatives and regional and national officers. The lines that were pursued were not necessarily identical to the ones that might have been adopted had an independent research study been designed. It is doubtful, however, whether crucial access to national and other full-time officials would have been granted given the defensive nature of many of the contributions, and certain that any responses would not have had the threat of perjury hanging over them.

The focus of the Francis Report was only in part on trade union practice. For the purposes of this study only contributions by and about unions were examined. Evidence comprised written submissions and verbal responses to cross examinations from: one General Secretary, one National Official, one Regional Official and three local shop stewards together with the Committee's reflections on them. In all this amounted to 100s of pages. There are a number of ways to analyse the features of successful trade unionism ranging from Kelly's (1998) attempt to promote mobilization theory, to various emphases within what has become known as the organizing model (Bronfenbrenner et al. 1998; Author A 2006; Simms et al. 2013). The data here are analysed using criteria from Fairbrother et al's organisational processes said to be indicative of renewal: 'recruitment and extension of the

membership base; replenishment of new generations of activist members; building workplace- and community-relevant structures and activity; mutually supportive relations between layered levels of representation' (2012: 41).

Disconnected Trade Unionism

The Royal College of Nursing

The RCN is the principal UK voice of the nursing professions with over 400,000 members, organized nationally into 15 regions. It sees itself as having two distinct but linked functions: a professional one and a trade union one. The former role involves delivering courses and presentations on nursing issues as well as 'creating policies and providing general advice on matters such as staffing levels' (Carter, Statement: 2) (quotations are from the Francis Inquiry unless otherwise stated). Although a Royal College, its powers are considerably less than other Royal Colleges in that it cannot enforce standards though it does seek to set them. Its trade union role immediately signals two significant characteristics. Firstly, it qualifies the conflict of interest between employers and its members through the assurance that "Each [RCN] Regional Director will have good relationships with the senior figures at the hospitals and Primary Care Trusts in their region'. Secondly it is a servicing organization: "It is fair to say we work for our members. The vast majority . . . join for indemnity and the support we can offer' (ibid.: 2). The membership section of its website (https://www.rcn.org.uk/membership) stresses that it also offers advice and the support to 4000 workplace representatives in planning, learning and health and safety requirements and a central career advice service; a campaigning voice; and a range of discounts. The model it holds is one of a respected pressure group: its professional role outweighs its trade union organization and representational roles. Tellingly, it is the Royal College of Nursing, not *Nurses*, and has as its patron Queen Elizabeth II.

Recruitment and extension of the membership base

RCN had approximately 500 members within the Trust in 2011 (Legan, Day 42: 104). The Trust's Annual Report 2008-9 stated there were 764 Nursing and Midwifery staff out of a total of approximately 3000 employees Allowing that some would belong to the Royal College of Midwives and some to UNISON, and that it accepts into membership Healthcare Assistants, the figures still suggest a high percentage of nurses were RCN members. Whatever the formal levels of membership and density

there was little in the way of collective consciousness and involvement. According to the lead RCN representative at the Hospital, who had 28 years as a representative, her main contact with members was 'Predominantly . . . through branch meetings (Breeze, Statement 2011: 4). However, members only attended branch meetings when there was a problem and then in very small numbers ('under ten') (Breeze: Day 42: 12). Another representative reported that nurses 'didn't really see the point of . . . talking to us, the RCN, because they didn't feel that we were being instrumental in making things any better' (Adams, Day 51: 28).

Replenishment of a new generation of activists

The organizational structure of the RCN was rudimentary. There were only three local representatives and a safety 'officer' during the period 2005-9 (when the branch also covered another hospital, community practices and members in the prison service, an estimated total membership of 1400) (Breeze, Day 42: 7). Nor were they distributed to ensure even coverage within or across the sites, with representation dependent upon who volunteered (ibid.: 7). The lead representative considered that the optimum numbers of representatives were between eight and ten but was fatalistic about increasing them: 'You can't pressurize people into becoming reps . . . and people don't come forward . . . because they don't like speaking up' (ibid.: 10). The few representatives were not overwhelmed with members' demands due to the lack of confidence in the RCN and positive encouragement not to utilize the organisation:

> If a member did have a problem with patient care, other than completing an incident reporting form members could raise concerns with their line manager (ibid.: 5).

It is hard to imagine that Breeze could have remained totally ignorant of the emerging problems of the hospital and her members' concerns. She, however, stated that no one had ever reported these to her and that she could not recall these issues being raised at joint staff side trade union meetings (JSSC). When asked whether she thought the threat to patient care, caused by redundancies, should have been raised at the Joint Negotiating and Consultation Committee (JNCC) she replied: 'I really can't comment on it', causing a sharp rejoinder from the Chair: 'Well you can because you were there' (ibid.: 48).

Evidence from other RCN representatives clarified whether Breeze's stance was exceptional or illustrated general practice of the RCN at the hospital. The second RCN representative, Sue Adams, a Day Unit Speciality Manager, had five years's experience as a representative at the time of the Inquiry. Her approach had a clearer representative orientation. When members reported problems or concerns to representatives, the latter 'were able to feed this information back to their lead stewards'. In turn, Breeze 'could escalate these matters to the Trust's Executive Team, at various forums, including JNCC, one-one meetings etc.' (Adams, Statement: 2-3). Adams gave every impression that she was much more alive to the issues of the hospital, which she discussed with the third representative, with whom she also visited wards to talk to members. The weakness in her account was suggesting that relaying issues to Breeze would guarantee they received attention. Nor was there evidence that reporting issues directly to the regional RCN was effective. Adams reported, for instance, that when concerns about the hospital ignoring incident reports were raised by a nurse 'nothing appears to have happened' (Adams, Day 51:65)

There were occasions when Adams objected to hospital policy both as a Day Ward Manager and an RCN union representative. In the former capacity she documented understaffing, writing in 2004 to a consultant podiatric surgeon about threats to patient care and detailing her unsuccessful attempts to have posts filled (Statement: 6). She raised concerns as an RCN representative over the amalgamation of the day and short-stay surgery wards at JNCC meetings. Failure to achieve anything stemmed not from her personal qualities but from a combination of the intransigence of the hospital and the ineffectiveness of the RCN as an organization.

Mutually supportive relations between layered levels of representation

RCN representatives needing support and advice received no leadership on major issues such as the move to gain Foundation Trust status, the financial preconditions of which exacerbated existing staff shortages. Adams' view was that 'the RCN were generally very laissez-faire, about the Foundation Trust proposal' and that officials 'proffered no view either way about whether Foundation Trust status was a good or bad thing' (ibid.: 10). More significantly, the Region seemed unconcerned about the state of union organization at the hospital. When questioned about the role of Breeze,

and her claimed lack of knowledge of widespread staff concerns about overwork and care quality, Adams insisted that she and the other steward raised them with her in numerous fora (ibid: 40). She took her concerns about Breeze's ineffectiveness to the Regional Office (ibid. 41): 'we needed more support because Denise wasn't able to come to meetings, she wasn't getting to go to patch meetings, she didn't always get to staff-side meeting'. Again there was no union response.

This situation would have been clear to the full-time officer, Adrian Legan, responsible for the hospital. Legan's remit was in part 'to support and develop local branch activity and advise and represent members in relation to employment issues' (Legan, Statement: 1-2). Patently, the development of the branch had been unsuccessful. There were too few RCN stewards, a complaint Legan endorsed. But on this, as other issues, he was at pains to point out that in this the hospital was typical: 'There are never enough staff representatives' (Legan 42: 112). Nor were low levels of membership participation abnormal: 'there was no more or less engagement in Stafford than any other organization or branch that I support' (Statement: 112). At Mid Staffordshire it is unclear what was done to alter this situation despite, according to Breeze, the full-time officer being there 'most of the time', a claim Legan disputed (Legan 42: 134). Breeze stated that 'He was always there on hand and dealt with all – anything major, any reorganization, anything like that' (Breeze 42: 98). Legan acknowledged that Breeze 'did tend to consult with me . . . when she did not have time to assist a member, and so she would contact our office' (Legan, Statement: 3). Breeze on her own admission did very little (Breeze 42: 19), a situation that Legan appeared not to question.

Given the extent of his involvement it might be expected that the full-time officer would be aware of the concerns about serious staff shortages, particularly as Adams maintains that the issue was discussed and reported. He maintained that, had he received a complaint of that nature, 'then I'm pretty confident that that would be retained at a regional level and acted upon' (Legan 42: 132): but he also added:

> . . . quite often the response from the trust [to staff shortages] would be that it was attributable to short-term sickness or they were aware . . . of

> global issues around staffing concerns and were addressing matters' (ibid; 132).

Management's contention that problems were restricted to short-term sickness, rather than to chronic and structural understaffing, appears to have been internalized: 'I think most of the concerns regarding staffing would have been around short-term sickness. So it would have been pertinent to a particular shift . . . it wasn't necessarily a long-term issue' (ibid.: 213).

Nurses might have found it harder to accept this view, although they would likely be entirely in the dark about the conversations that gave rise to it. RCN representatives were not told of the nature and outcome of meetings between RCN officials and management. Despite frequent meetings between Legan and the Chief Executive of the Trust (CEO), for instance, Adams reported:

> As a steward I was not told when the full-time officers at the RCN were visiting the Trust. This meant it was very difficult to know when they were speaking to the Trust's Executive team and whether any issues were being raised or acted upon (Statement: 4).

The debilitating effect of this approach to members and representatives also impacted directly in other ways. Legan's close relations with management, were apparent in the case of the nurse whistleblower, Helene Donnelly, who reported bullying, poor care standards and falsification of records in the Accident and Emergency department (A&E) resulting in the suspension of two Sisters. She sought support from Legan (Donnelly, Statement: 8). Initially he appeared 'horrified by what was happening in A&E', but she was disappointed that she didn't hear back from him for some time. When she did hear, he informed her that the Sisters 'had received a slap on the wrist' and would shortly be returning to work, that team building was to be scheduled and that 'everything would be fine' (ibid.: 8). She felt exposed and vulnerable and later discovered that he was representing at least one of the sisters in discussions with the trust. The Inquiry discovered that the Sisters did indeed return with a first warning as a result of a private agreement between Mr Legan and Martin Yeates [the CEO][i].

The way the RCN conducted itself at Mid Staffordshire was not unique. There was widespread disengagement of members, with a reluctance to report issues to the RCN. Peter Carter, its Chief Executive and General Secretary, cited the example of the problems at Maidstone and Tunbridge Wells NHS Trust, 'which included reports of patients being left in excrement and beds being only 8 inches apart' that 'were never raised by any of our members' (ibid.: 3). The apparent imperative of close relations between management and the RCN, as at Mid Staffordshire, to the exclusion of dialogues with its membership, was also indicated by Carter: 'If there are no issues in a particular hospital, the officer may not visit the hospital at all . . . However, these officers may call the Director of Nursing to ask if they can visit to discuss matters generally' (Carter Statement: 4-5).

The collaborative orientation of the RCN informed the nature of the visit that Carter made to Mid Staffordshire Hospital shortly before the Health Care Commission Report (2008) revealed the care crisis. Carter neither sought, nor was given, a prior briefing on the serious issues at the Trust (Carter 52: 24). On the visit he met two full-time staff from the regional office and also the hospital Chief Executive and the Director of Nursing. He could not recall whether he had met Sue Adams (he did not) and his tour of the hospital was conducted with the RCN senior full-time officer and the Director of Nursing. He made no attempt to meet his members, was not informed of any issues, nor saw evidence of understaffing and poor patient care.

Following the visit, the CEO wrote and thanked him particularly for how the RCN had been repositioned 'in terms of constructive and supportive dialogue as we face inevitable change in the NHS' (Exhibit PC1). Carter (Statement: 7-8) believed this reference related to the fact that: 'In the past, the RCN had been quite conservative in relation to change'. In contrast, the RCN was now 'repositioned to support change in the interests of patient care' which 'can often be difficult for our members to understand'. In his willingness to support the hospital, Carter wrote to the Director of Nursing saying: 'I have seldom been as impressed with the standard of care as I witnessed at Stafford Hospital' (ibid,: 8). He also wrote a letter with similar sentiments to the local newspaper. It was not until after the publication of the HCC Report (2008) that Carter returned to Stafford for a meeting with his members.

Responses to Francis

UNISON

The RCN is not a typical union seeking as it does to be both a representative and a professional body. For this reason alone it would not possible to regard its health as indicative of the state of public sector unionism. The position of UNISON is much more central with over 1.2 million members across the public sector of which around 450,000 members are in the health service (Jennings: Statement). Clearly it is a major player in industrial relations within hospitals. It also claims to be an 'organizing union' (Waddington and Kerr 2009) although, as indicated above, there is much evidence to challenge this. Moreover as Saundry and Wibberley (2013: 296) have concluded, illustrating a problem that was all too apparent at Mid Staffordshire:

> the erosion of collective bargaining has locked local branches into a dynamic of individual representation whereby a small number of activists are placed under increasing strain in responding to a growing caseload. This has arguably produced a dependent and remote relationship between union members, their branches, and their full-time officers.

Recruitment and extension of the membership base

UNISON had 814 members in the Hospital, comprising nurses, ancillary and clerical employees. No breakdown of its membership figures was available but only a minority would have been nurses, giving the RCN the lead voice in matters that were specific to this role. According to UNISON branch secretary, Kath Fox, 'there was always good attendance' at annual general meetings and 'if there was a particularly contentious issue going on, there would usually be about twenty people at branch meetings' (Witness Statement: 2). There was no evidence, however, of increased membership numbers or activity and certainly nothing resembling an organizing culture had taken hold.

Replenishment of a new generation of activists

UNISON was formally better organized than the RCN, having eight representatives in the hospital for the 800 or so members and mechanisms existed for positions to be

contested through nominations and elections. The leading figure of UNISON, Kath Fox, was a Bereavement Officer, who had nearly 20 years' experience in the union, performing roles from representing members at stage one sickness reviews to negotiating pay reviews with management. She also attended UNISON meetings at weekends and consequently felt pressed for time and unsupported:

> When I first became a trade union rep, we would deal with things such as normal day-to-day grievances, sickness reviews, that type of thing . . . now – your local reps are expected to do the role of full-time, paid trade union official, and we can't do that and hold a job down at the same time (Fox Day 43: 129).

While there is no evidence of replenishment of activists, the representatives were not inactive. Like Sue Adams, Fox insisted that representatives had raised staff shortages from 2005 onwards and that these concerns were not accurately reflected in JNCC minutes. She acknowledged that unions had not raised patient safety as such at the meetings but maintained: 'It was taken for granted that if you had a fully staffed ward patients would receive the proper care' (Fox Statement: 7). The responses to concerns raised by unions about understaffing were generally 'that staffing levels were adequate in the "professional view"' (ibid.: 7).

Mutually supportive relations between layered levels of representation

While the role of the RCN official was arguably conservative, his presence was undeniable and his influence tangible. In contrast, the role of the UNISON full-time officer was almost entirely absent and the links between the workplace and the region negligible. When asked about escalating issues through the union, Fox testified that escalation should come through the take up of issues by the Regional bodies and that the UNISON full-time officer frequently attended JNCC meetings so that regional officials would therefore have been aware of the hospital's problems. After a recess, counsel for the Inquiry, having had JNCC minutes from 2005 and 2009 examined, found that attendance had been restricted to one occasion. Fox responded that the minutes of every meeting would be automatically forwarded to the regional officer but was forced to admit that, while she hoped that the minutes were read, no one ever got in touch to discuss any of the issues contained within them.

No evidence was produced of any regular (or even occasional) inquiry about local developments by the UNISON regional office. As a result of this lack of engagement, and because 'none of the ftos [full-time officers] were taking - or appeared to be taking things seriously', the branch looked for other ways of raising concerns about understaffing and decided to send Fox to see David Kidney, Labour MP for Stafford, to determine 'whether he could do anything' (Fox, 43: 114). This avenue was closed, however, when Kidney was reassured by the hospital CEO that processes were in place to alleviate the concerns and wrote to Fox to that effect.

Unfortunately the UNISON regional official made no statement: nor was she heard at the enquiry. Had she been, the practice and thinking of the union might have been further scrutinized. However, the national secretary for health, Karen Jennings, both made a statement and was questioned at the Inquiry (by which time she had been promoted to an assistant general secretary). She described the role of the national office as 'very strategic' focusing on national bargaining and developing policies and guidance for members that was cascaded down (Jennings, 43: 8). Regional officers were available to 'give advice to branches when they can't handle something or they have concerns about something, or where they need further expert advice' (ibid.: 12). There appeared to be no apparent mechanisms for discovering when the relationship was not working. The regional officer's absence from the trust only became apparent after Jennings' evidence and she was not confronted about it. When reflecting on the fact that the national union knew nothing of issues at Mid Staffordshire, Jennings stated that 'it was perfectly open for the branch to write directly [to national office] on these matters' (ibid: 20). To the suggestion that going to an MP to raise the issues demonstrated desperation on the part of the branch, Jennings again reiterated that 'it is up to the branch to feel that they can come to the national office. It is up to the regional office to raise it with the national office' (ibid.: 20).

National officials' roles were portrayed as passive and constrained. When asked about systems for monitoring trends and developments she responded that they could only established if there was an instruction from their regions or annual conference: 'our primary aim throughout the year will be looking at what we've been mandated to do' (43: 22). Asked about individual issues communicated directly to the national

office, Jennings stated: 'we . . . refer that letter to the regional office and to the branch to deal with'. When pointed out that letters in relation to Mid Staffordshire would therefore probably have ended up back on Fox's desk, her reply is 'Or the regional office' (43: 28): the very places which seemed incapable of dealing with them.

Building workplace and community relevant structures and activity: Unions and the JNCC

The prime forum for joint trade union activity at hospital level was the JNCC. Representatives of other JNCC unions were wary of the RCN because of the relationship between Legan and the trust management. UNISON representative, Kath Fox, stated that the RCN, and Legan in particular, played a key role in the JNCC but also outside of it: 'meetings were taking place between the RCN full time officer and management . . . outside the context of the JNCC, which undermines the JNCC role' (Fox Statement: 12). Legan's testimony reinforces the claim. When replying to questions about redundancies and understaffing he revealed:

> I was constantly reassured that even when there was talk of 180 posts [to be made redundant] that these would not include front-line nursing staff . . . but predominantly would be looking at other areas, not necessarily clinical areas (42: 156).

Such reassurances were given when the other unions, as the principal causalities of this policy, would not have been present.

Nevertheless, there was united union opposition of sorts when in 2006 the trust proposed 180 redundancies. Staff unions coalesced around resisting both compulsory redundancies and the shortening of the consultation period from the statutory 90 to 30 days. The lead official in this resistance was the full-time officer from Unite, with a much smaller healthcare membership. While the Trust quickly, if reluctantly, conceded on the issue of complying with the statutory redundancy consultation period, and relented on the compulsory nature of the redundancies, these changes did nothing to save any jobs, which, the Inquiry concluded, seriously impacted on patient

care. Voluntary redundancies and normal staff turnover exacerbated the already chronic understaffing, worsened conditions, increased pressure and further lowered health care standards.

There was no attempt by representatives to mobilize members or to use other avenues to challenge management. No mention is made of attempts to gain evidence of the impact of the redundancies by conducting a members' survey, holding ward or site meetings, or insisting on union involvement in the risk assessment to which unions were entitled. No links were made with those nurses who had signed a collective letter of protest. Neither is there any mention of contacting the HCC, the service regulator, or the Nursing and Midwifery Council, the professional regulator for advice. Statutory rights were not utilised: TULCRA s.188 (4) requires employers to meaningfully consult and to provide the real reasons (and supporting information) for redundancies. The Trust had no accurate record of how many nurses it employed, nor was it able to show the Inquiry any clinical risk assessment of the impact of planned cuts indicating that a challenge to them would have caused difficulties.

Conclusion: The Duty of Care and Trade Unionism

The evidence here joins a growing body of work documenting problems faced by public sector unions. RCN and UNISON had substantial memberships at Mid Staffordshire but were unable or unwilling to mobilize them around important workplace issues. The internal relations were as those described by Saundrey and Wibberley (2013): dependent and remote between union members, their branches, and their full-time officers. Little wonder that members, with a few notable and isolated exceptions, were, as elsewhere (Bach 2004), demoralized, quiescent and complicit in the accepting poor standards. Members of both unions, like those studied by Cooke (2006a), endured heavy work demands and struggled to provide care with unacceptably few resources. Their commitment to patients found no way of asserting itself and coalescing as a force against hospital policies. Had the trade unions successfully demanded that patients received adequate and safe care, staff conditions, satisfaction and morale would have improved, making staff allies with patients and relatives groups. Instead, the demand was never clearly made despite independent staff surveys suggesting deep dissatisfaction with the standard of care in the hospital.

Within Mid Staffordshire both unions maintained they were largely (and in the case of UNISON entirely) unaware of the problems of understaffing and poor healthcare provision: it is a defense that is at the same time an indictment. Though the RCN referred to its policy document on staffing levels, neither union had a strategy for linking understaffing and working conditions to good healthcare standards despite an abundance of easily available evidence. The absence of such a strategy was highlighted in their opposition to compulsory redundancies, leading the Francis Inquiry's counsel to comment:

> This episode did show the trade unions standing their ground and protecting their members' rights. It showed them operating in their natural sphere rather than concerning themselves with the risks to patients arising from the proposed redundancies. (Francis Report: final written submission: 376)

An alternative strategy could have mobilized members around their professional code of conduct and the hospital's duty of care. In order to practice, nurses have to be registered with the Nursing and Midwifery Council (NMC), and registration requires adherence to its professional code of conduct. As only registered nurses can be employed, adherence to the code becomes an implicit part of nurses' contracts of employment and they cannot be asked to breach it directly or ask other staff to breach it. Had the unions documented unsafe practices and, for instance, only followed written instructions to work in such situations, managements' culpability would have been visible, embarrassing and unsustainable. Often senior staff issuing instructions are also registered practitioners and subject to same professional codes. Indeed, in January 2014, the director and chief nurse responsible for nursing at Mid Staffordshire was struck off the NMC register after it was found that she had endangered patients, and that she had shown no insight into her failings (*Nursing Times* 29 January 2014).

Rather than highlighting the employers' responsibility to enable safe practice, the RCN accepted the senior nurse's individualization of nurse responsibilities to abide by their professional code of practice, thus leaving staff open to threats from managers. Sue Adams (Statement: 16) reported that nursing staffs were told that 'if

they considered staffing levels were unsafe that this was a breach of the NMC Code of Conduct . . . and they should be very careful about what they put in a formal complaint as it might lead to them losing their job'. Fox (Statement: 9) reflected a similar sentiment, stating: 'From everything I have learnt, professional standards and accountability is down to the individual nurse and not UNISON to maintain'. This narrow interpretation deflects attention from managements' over-riding responsibilities towards both patients and their staff. Failure to effectively challenge this management approach thus marginalized patient safety as an issue around which to mobilise.

RCN representation is dominated by senior staffs (Hart 1994) and has a professional orientation. It has authoritative guidelines and recommendations on good nursing practice and as early as 2006 published research on the impact of low staffing levels. However, it had little organization at the workplace and its Annual Report (2013) suggested that this was part of a wider problem: 'Numbers of representatives continue to decline, due in part to the impact of the tough economic climate on NHS and independent providers and i*n part to a policy decision to focus on quality standards*' (2013: 7) (emphasis added). Campaigning for staffing ratios without local organization to monitor or enforce them will likely prove ineffective, especially if, as in Mid Staffordshire, officials are more comfortable talking to directors than mobilising members, making a change of direction difficult. UNISON, on the other hand, encouraged a routinised trade union response that largely ignored issues of work organization and content. As its Head of Nursing framed it: 'We are a trade union, not a professional association' (Nursing Times: 14/5/2013). There is little indication that within UNISON occupational identities and related workplace concerns are treated as issues around which to mobilize. Even where UNISON produces national guidelines over staffing levels, for instance, it increasingly does not have the organization to negotiate or enforce them at the workplace, and members' day-to-day concerns risk escaping practical attention.

In the wake of the Francis Report both unions published responses. The lengthy RCN response (RCN 2013b: 5) stated that:

> Robert Francis discussed the role of the RCN in his report and highlighted that we could have done more locally to support our members on the ground. This is something the RCN readily acknowledged in its initial response to the report (6 February 2013).

It added:

> Since the events at Stafford Hospital were first reported, we have undertaken significant work to improve the support we provide our accredited representatives and active members, and to improve the way our members can raise concerns about standards of care (ibid.: 8).

UNISON's much later, much shorter response (UNISON 2013) included no acknowledgement of, or reflection on, any of its own shortcomings in Mid Staffordshire, nor any lessons learned by the union. Neither union has drawn the conclusion that they need to move towards an 'organising ' approach'.

Britain will almost certainly continue to witness public sector strikes, albeit largely one day and symbolic. Resistance to concerted reductions in the living standards of their members, especially in the public sector, has largely been ineffectual and certainly has not been able to reverse any of the major government policies worsening pensions, retirement ages and pay. A concentration on these issues, to the exclusion of engagement with the daily issues that confront their members within the workplace will likely see further detachment and disillusionment with trade unions. Nor is the solution to hope that Labour win the next election in 2020. All the circumstances propelling the Mid Staffordshire crisis occurred under a Labour government and throughout its period of office trade union fortunes declined. Unions in the public sector, but not exclusively, have the ability to champion public service standards and in doing so engage and enthuse members who continue to care for the services they provide. This entails changing strategies and in the process having an internal fight to transform the unions into really effective organizations. To fail to do this will have societal consequences well beyond the reduction of unions to smaller organizations characterized as special interest groups.

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